**DIVISION OF SERVICES FOR PEOPLE WITH DISABILITIES**



# SOCIAL SUMMARY

MM DD YY
Today's Date: ___/___/___

## 1. FAMILY INFORMATION

Person's DOB: ___/___/___ Person's Social Security Number: __ __ __- __ __ -__ __ __ __

| Name | Address | Phone Number |
|---|---|---|
| Person: | | ( )- |
| Mother: | | ( )- |
| Father: | | ( )- |
| Sibling: | | ( )- |
| Sibling: | | ( )- |
| Sibling: | | ( )- |

## 2. CURRENT SITUATION (mood changes, behavioral problems, family changes, law enforcement issues, etc.)

## 3. FAMILY HISTORY (information about the person's disability or medical problems in extended families)

## 4. EMERGENCY CONTACTS

| Name | Address | Phone Number |
|---|---|---|
| Physician: | | ( )- |
| Dentist: | | ( )- |
| Responsible Party: | | ( )- |
| Guardian: | | ( )- |

## 5. EDUCATIONAL HISTORY

Was/is person in special education? ❒ Yes ❒ No

## 6. WORK AND/OR DAY SUPPORT HISTORY ❒ Yes ❒ No

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**7. COMMUNITY LIVING** (Parents' home, foster care, institution, etc.):

**8. CURRENT NATURAL SUPPORT SYSTEM** (Family, friends, church, etc.):

**9. CURRENT MEDICATIONS**

| | | |
|---|---|---|
| Name | Dosage | Reason |
| Name | Dosage | Reason |
| Name | Dosage | Reason |
| Name | Dosage | Reason |
| Name | Dosage | Reason |
| Name | Dosage | Reason |
| Name | Dosage | Reason |

**10. PHYSICAL, MEDICAL, OR MENTAL HEALTH, CONSIDERATION IN SERVICE PLANNING:**

**11. OTHER COMMENTS:**

Support Coordinator's Signature

Date

QMRP Signature (if applicable)

Date